pretend to go to all meals and caught rides whenever we could. Frequently the people came after us, when it was very stormy or bad under foot.

In spite of bad conditions, with one exception, the patients gradually improved, making the experience very interesting at least. They all did very nicely except one little boy, who died on Christmas morning, making it a sad day for all concerned. This little fellow had never been well during his brief six years of life, having been subject to diabetes from his infancy. He was very much undersized, and was the thinnest child I ever saw, when he died. When the fever subsided he didn't have sufficient vitality to recuperate. Kidney, bowel and heart complications set in and soon overcame all power of resistance in the frail little body.

The trained nurse stayed with me less than two weeks, after which I was obliged to depend on practical nurses for the rest of the time. But the worst was over, and by the end of two more weeks all were able to sit up, and I left them in care of the experienced nurse. Later I learned that the family had been broken up for the time being and divided among the relatives.

POST-OPERATIVE GASTRIC DILATATION

By MARY M. A. WEISS, R.N.,
Graduate of the Margaret Fahnestock Training School, New York City

Perhaps some of the late graduates have not learned and will find it useful to know that post-operative distension in the upper abdomen is not always due to flatus as is often supposed, but is occasionally caused by an accumulation of fluid in the stomach which is not forced through the pylorus or may even regurgitate from the duodenum because the muscular tone of the stomach (which is lost in the general paresis produced by ether) has not been regained.

A patient who taught this lesson was a nervous and emaciated little unmarried woman who had been teaching for seventeen years. The expression of her eyes made one feel her mind was not quite well poised, but as she was never seen by the nurses until the day preceding operation, this symptom and the restlessness may, of course, have been due entirely to the extreme nervous tension under which she seemed to be laboring and which (a very poor preparation for operation), produced a sleepless night.

The operations performed were, a hysterectomy, appendectomy, hemorrhoidectomy and nephropexy, the last named being especially trying because of the weariness occasioned by the long continuance in the necessary dorsal position. A needed operation for the removal of gall-

stones was omitted because of the general poor condition of the patient while on the table.

Post-operative cathartics were not ordered quite as soon as is customary, in order that the anal region might not be more irritated. Tympanites became apparent and the patient was restless, getting but few five- to twenty-minute intervals of sleep, morphine having no effect at first, and being contraindicated later because of the sluggishness of the bowels. Eserine salicylate, gr. 1/40, q. 4 h., per hypodermic, purgatives and enemata were ineffectual for some time and the patient began to complain of "sour stomach" and to expectorate small amounts of bitter tasting brownish fluid.

On the fourth night her hands were clammy and jactitation extreme (supposedly symptoms of nervousness) and pulse (112), small. By midnight the patient seemed to be in a dying condition, with a feeble pulse of 144 and was permitted to roll about, regardless of kidney fixation. The doctor was called and ordered stat. camphor, gr. $\frac{1}{5}$, per hypodermic, the high insertion of a rectal tube to relieve flatulence, a gastric lavage of soda bicarb. solution, ℥i, to Oi. A purgative enema was to be given one hour later if the cathartics given previously were not effectual, and strychnia, gr. 1/30, q. 4. h., per hypodermic. Flatus was expelled and normal feces discovered on the rectal tube, proving there was no intestinal obstruction as was suspected.

About O $\frac{1}{2}$ of greenish brown fluid was extracted from the stomach and the epigastric region became soft immediately after lavage. Her pulse improved, her hands became warm and the patient felt so relieved and well that she wished to know how soon the nurse might be dismissed. By 5 A.M., the bowels were moving, accompanied by the expulsion of much flatus and it seemed as though nourishment and rest alone were needed to insure perfect recovery.

By 10 A.M. gastric distension again necessitated the use of the Politzer bag, and ℥xxxii of fluid were obtained. A state of collapse was rapidly reached and Fowler's position and camphor ordered, also an intravenous saline infusion. For the first time since the operation there was a temperature (103°). Death occurred at 4 P.M.

It is not irony to state in this case that "the operations were successful but the patient died," because it was clearly proven that the wounds were in excellent condition. I was told that there was not sufficient vitality to overcome the general asthenia and to recover the muscular tone after the paresis caused by anesthesia. The intestinal contents regurgitated into the stomach, which, when filled, forced the diaphragm against the heart, and it was this pressure which retarded circulation and caused the cold hands and running pulse.